EXHIBIT A

E[redacted], Madison[redacted]

MRN: 103577429

William K Boss, MD
Physician
Plastic Surgery

Operative Report
Signed

Date of Service: 12/10/2018 0:00

SURGEON: William K. Boss M.D.
CO-SURGEON: N/A
ASSISTANT: None.
ANESTHESIOLOGIST:
DATE: 12/10/2018
OPERATION: Reconstruction of the extraoral mucosa, the orbicularis oris musculature, the vermilion border, the dermis and subcutaneous tissues.
ANESTHESIA:
PRE-OP DX: A 1.5 cm traumatic cleft of the left upper lip.
POST-OP DX: A 1.5 cm traumatic cleft of the left upper lip.

HISTORY: This patient had a seizure while in her school bus, fell to the ground and struck her face. She came to the emergency. She was seen by Dr. Hyppolite who evaluated her, requested plastic surgical repair and cleared of any other injuries. My examination indicated the dental occlusion was unchanged. The dentition was intact. There was no diplopia. Extraocular muscle motion was intact. The pupils were equal and reactive to light and accommodation. There are no limitations. There is no diplopia in any fields of gaze.

PROCEDURE: The patient was placed in the emergency operating stretcher and infiltrated with 1% Xylocaine with epinephrine. She was prepped and draped with Betadine solution, sterile towels and drapes. Operating loupe magnification of 4.5X was utilized.

The extraoral mucosa was repaired with interrupted and continuous 5-0 Vicryl sutures. The vermillion border was approximated with a key suture at the vermilion border junction internally with the dermis and subcutaneous and the mucosa. This key suture approximated that critical structure. The orbicularis oris musculature was repaired with interrupted 6-0 Vicryl simple sutures. The dermis and subcutaneous were approximated with interrupted 6-0 Vicryl with the knots inverted. The superficial dermis and epidermis were approximated with a continuous 7-0 Ethilon simple suture technique that extended past the vermilion border into the extraoral mucosa. A light coat of bacitracin was applied.

The family was instructed on local wound care to washout, pat dry, not to expose it to large amounts water, pat it dry and put a very thin coat of bacitracin or Polysporin on it.

CC: William K. Boss M.D.
Alex Hyppolite, M.D.

Last signed by: William K Boss, MD at 12/13/2018 10:13

ED on
12/10/2018

EXHIBIT B

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to William K. Boss, M.D. and Sidney Rabinowitz, M.D. (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of the Providers, or their attorney (or other representative) to (I) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to William K. Boss, M.D. or Sidney Rabinowitz, M.D. for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative my Provider and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate" under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.

2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.

3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.

4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.

5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third- party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: Madison [redacted]

Date: 12/12/18

Patient Signature: [redacted]

EXHIBIT C

UHC Oxford
PO Box 29130
Hot Springs AR 71903

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
							1364315504		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX M	SEX F X		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
[redacted] Madison			[redacted]				[redacted]		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
[redacted]			Self	Spouse	Child X	Other	[redacted]		
CITY	STATE		8. RESERVED FOR NUCC USE				CITY	STATE	
[redacted]	NJ						[redacted]	NJ	
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE	TELEPHONE (Include Area Code)	
[redacted]	[redacted]						[redacted]	[redacted]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
							IP6439		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX	
			YES	NO X			[redacted]	M X	F
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?	PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)		
			YES	NO X					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES	NO X			OXFORD HEALTH PLANS		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							YES NO X *If yes,* complete items 9, 9a, and 9d.		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature On File DATE 11 06 19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature On File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Hyppolite Alex	17a. 17b. NPI 1881868511	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO X $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. S01 511A B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 10 18	12 10 18	23		13151		A	9500 00	1		NPI	1598769317
2	12 10 18	12 10 18	23		99281	25	A	150 00	1		NPI	1598769317
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
22 2409403 X	1118562	X YES NO	$ 9650 00	$ 1215 35	8434 65

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) William K Boss MD 11 06 19 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION Hackensack University Medical Center 30 Prospect Avenue Hackensack NJ 076012570 a. 1457456279 b.	33. BILLING PROVIDER INFO & PH # (201 967 1100) Boss MD William K 305 Route 17 South Suite 3 100A Paramus NJ 07652 2913 a. 1124279732 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT D

089OXOPPR0011001-03328-02

Oxford Health Insurance Inc
UnitedHealthcare - Oxford
4 Research Drive
Shelton CT 06484
Phone: 1-800-666-1353

STD - PRA

UnitedHealthcare Oxford

PROVIDER REMITTANCE ADVICE

CHECK DATE: 01/08/19
TIN: 222409403
VENDOR NAME: WILLIAM K BOSS JR MD PA
CHECK NUMBER: 25986906
CHECK AMOUNT: $2,206.41
VENDOR ID: P903887-P1263166

WILLIAM K BOSS JR MD PA
305 RTE 17 S STE 3-100A
PARAMUS NJ 07652

PATIENT: MADISON [redacted]

MEMBER ID: 13643155*04 PATIENT ACCT NUM: 1119562
PROVIDER ID: P1263166
CLAIM NUMBER: 8348E25100
PROVIDER NAME: BOSS JR, WILLIAM

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	QTY	BILLED AMT	MAXIMUM AMOUNT	DEDUCTIBLE AMT	COPAY/COINS AMT	COB AMT	WITHHOLD AMT	PAYMENT AMT	PATIENT RESP AMT	ADJ CODE
12/10/18	REPAIR OF WOUND OR LESION (13151)	1	$9,500.00	$1,135.23			$0.00	$0.00	$1,135.23	$0.00	A88R
12/10/18	EMERGENCY DEPT VISIT (99281-25)	1	$150.00	$80.12			$0.00	$0.00	$80.12	$0.00	A88R
CLAIM 8348E25100 SUBTOTAL			$9,650.00	$1,215.35			$0.00	$0.00	$1,215.35	$0.00	

PATIENT: [redacted]

MEMBER ID: [redacted] PATIENT ACCT NUM: [redacted]
PROVIDER ID: P1263166
CLAIM NUMBER: 8348E25175
PROVIDER NAME: BOSS JR, WILLIAM

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	QTY	BILLED AMT	MAXIMUM AMOUNT	DEDUCTIBLE AMT	COPAY/COINS AMT	COB AMT	WITHHOLD AMT	PAYMENT AMT	PATIENT RESP AMT	ADJ CODE
12/12/18	REPAIR OF WOUND OR LESION (13131)	1	$7,750.00	$991.06			$0.00	$0.00	$991.06	$0.00	A88R
12/12/18	EMERGENCY DEPT VISIT (99284-25)	1	$150.00	$80.12	$80.12		$0.00	$0.00	$0.00	$80.12	A88R
CLAIM 8348E25175 SUBTOTAL			$7,900.00	$1,071.18	$80.12		$0.00	$0.00	$991.06	$80.12	
								TOTAL PAYABLE TO PROVIDER		$2,206.41	

Adjustment Code Description

A88R You do not participate in our network. As a result, the claim has been paid at 350% of the rate established by the federal government for the Medicare program for the services provided. The member is only responsible for any copayment, coinsurance and deductible amounts shown on this Remittance Advice statement. Please DO NOT contact our member about any other amounts and DO NOT balance bill the member. Contact Provider Services if you have any questions concerning the processing of this claim at 800-666-1353.

For the above claims please visit www.oxhp.com

EXHIBIT E

This report is in a draft status until authenticated by the responsible provider

The Valley Hospital Operative Report

ACCT#: V0009979026

PATIENT: E[redacted], Coby MR # M1524290

DATE OF OPERATION: 12/12/2018

SURGEON: William Boss, MD

PREOPERATIVE DIAGNOSIS: 2.0 cm complex chin laceration.

POSTOPERATIVE DIAGNOSIS: 2.0 cm complex chin laceration.

OPERATIVE PROCEDURE: Primary scar revision and wound excision with complex repair of the mentalis musculature, subcutaneous tissues, dermis and integument.

SURGEON: William Boss, M.D.

ASSISTANTS: None.

HISTORY: This patient fell out of bed last evening, suffered the aforementioned laceration in the central portion of his chin. He was brought to the emergency room where plastic surgical reconstruction was requested by the emergency room pediatrician, who cleared the child of any other injury requested I reconstruct the wounds, and the pediatrician would order the appropriate antibiotics.

PROCEDURE: The patient was placed on the emergency room operating stretcher, restrained using a child papoose restraint. Wound margin was infiltrated with 1% Xylocaine with epinephrine, as was the deep tissues, including the mentalis musculature. Operating loupe magnification of 4.5X was utilized. The wound margins were jagged and irregular, and they were excised and revised with a curved iris scissors. The mentalis musculature was repaired with interrupted 5-0 Vicryl simple sutures. The wound margins were undermined at the subcutaneous junction with the deep musculature to advance for closure. Subcutaneous tissues and deep dermis were approximated with interrupted 6-0 Vicryl simple sutures with the knots inverted. The middle dermis was approximated with a continuous 6-0 Vicryl subcuticular suture. The superficial dermis and epidermis were approximated with interrupted and continuous 7-0 Prolene. The wounds were dressed with Xeroform, 4 x 4 gauze pad, 0.5 inch Steri-Strips. Family was instructed to keep the dressing clean, dry and intact. His activity should be limited. They can change her dressing on Sunday, wash with cleanser, pat it dry and then put on bacitracin ointment with a Band-Aid. They are instructed to return to see me next week for reevaluation and suture removal.

William Boss, MD
DD: 12/12/2018 09:27
TD: 12/12/2018 09:34
Job #: 183734890

The Valley Hospital
Patient Name: [redacted], Coby
Patient DOB: [redacted]
Account #: V009979026

CRC: Epstein, Coby/M1524290

<Electronically signed by William K. Boss, Jr, MD> at 12/13/18 1049

cc: Boss, William K. Jr MD^

EXHIBIT F

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to William K. Boss, M.D. and Sidney Rabinowitz, M.D. (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to William K. Boss, M.D. or Sidney Rabinowitz, M.D. for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative my Provider and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate" under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.

2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.

3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.

4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.

5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third- party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: Cosl, [redacted]

Date: 12/19/18

Patient Signature: [redacted]

EXHIBIT G

UHC Oxford
PO Box 29130
Hot Springs AR 71903

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1308498907

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
[redacted] Coby	[redacted]	M X F	[redacted]

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
[redacted]	Self Spouse Child X Other	[redacted]

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
[redacted]	NJ		[redacted]	NJ

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
[redacted]	[redacted]	[redacted]	[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY [redacted] SEX M F X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: OXFORD HEALTH PLANS
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature On File DATE 11 06 19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature On File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES X NO $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. S01 81XA B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 12 18	12 12 18	23		13131		A	7750 00	1		NPI	1598769317
2	12 12 18	12 12 18	23		99281	25	A	150 00	1		NPI	1598769317
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
22 2409403	1118570	X YES NO	$ 7900 00	$ 991 06	6908 94

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (201 967 1100)
William K Boss MD 11 06 19 SIGNED DATE	Valley Hospital 223 North Van Dien Avenue Ridgewood NJ 074502726 a. 1013912633 b.	Boss MD William K 305 Route 17 South Suite 3 100A Paramus NJ 07652 2913 a. 1124279732 b.

EXHIBIT H

009OXOPPR0011001-03328-02

Oxford Health Insurance Inc
UnitedHealthcare - Oxford
4 Research Drive
Shelton CT 06484
Phone: 1-800-666-1353

STD - PRA

UnitedHealthcare Oxford

PROVIDER REMITTANCE ADVICE

CHECK DATE: 01/08/19
TIN: 222409403
VENDOR NAME: WILLIAM K BOSS JR MD PA
CHECK NUMBER: 26986905
CHECK AMOUNT: $2,206.41
VENDOR ID: P003887-P1283166

WILLIAM K BOSS JR MD PA
305 RTE 17 S STE 3-100A
PARAMUS NJ 07652

PATIENT [redacted]

MEMBER ID: [redacted]
PROVIDER ID: P1283166
CLAIM NUMBER: [redacted]
PROVIDER NAME: [redacted]

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	QTY	BILLED AMT	MAXIMUM AMOUNT	DEDUCTIBLE AMT	COPAY/COINS AMT	COB AMT	WITHHOLD AMT	PAYMENT AMT	PATIENT RESP AMT	ADJ CODE
12/10/18	REPAIR OF WOUND OR LESION (13151)	1	$9,500.00	$1,135.23			$0.00	$0.00	$1,135.23	$0.00	A88R
12/10/18	EMERGENCY DEPT VISIT (99281-25)	1	$150.00	$80.12			$0.00	$0.00	$80.12	$0.00	A88R
CLAIM 8348E25100 SUBTOTAL			$9,650.00	$1,215.35			$0.00	$0.00	$1,215.35	$0.00	

PATIENT: COBY [redacted]

MEMBER ID: 19084989'07
PROVIDER ID: P1283166
PATIENT ACCT NUM: 1118570
CLAIM NUMBER: 8348E25175
PROVIDER NAME: BOSS JR, WILLIAM

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	QTY	BILLED AMT	MAXIMUM AMOUNT	DEDUCTIBLE AMT	COPAY/COINS AMT	COB AMT	WITHHOLD AMT	PAYMENT AMT	PATIENT RESP AMT	ADJ CODE
12/12/18	REPAIR OF WOUND OR LESION (13161)	1	$7,750.00	$991.06			$0.00	$0.00	$991.06	$0.00	A88R
12/12/18	EMERGENCY DEPT VISIT (99281-25)	1	$150.00	$80.12	$80.12		$0.00	$0.00	$0.00	$80.12	A88R
CLAIM 8348E25175 SUBTOTAL			$7,900.00	$1,071.18	$80.12		$0.00	$0.00	$991.06	$80.12	
								TOTAL PAYABLE TO PROVIDER		$2,206.41	

Adjustment Code Description

A88R You do not participate in our network. As a result, the claim has been paid at 350% of the rate established by the federal government for the Medicare program for the services provided. The member is only responsible for any copayment, coinsurance and deductible amounts shown on this Remittance Advice statement. Please DO NOT contact our member about any other amounts and DO NOT balance bill the member. Contact Provider Services if you have any questions concerning the processing of this claim at 800-666-1353.

For the above claims please visit www.oxhp.com